KLEBER HEALTH CLINIC

BLDG 3287 A, KLEBER KASERNE

DSN: 590-2612; CIV: 0637194642612

EXCEPTIONAL FAMILY MEMBER PROGRAM PACKET

Packet Contents

KLEBER CLINIC CONTACT SHEET

Mrs. Kesha Luckett
EFMP Coordinator……DSN: 590-2612
Civ: 0637194642612

Dixon, Jacquline
SPC, EFMP
Tech……DSN: 590-2643
Civ: 0637194642643

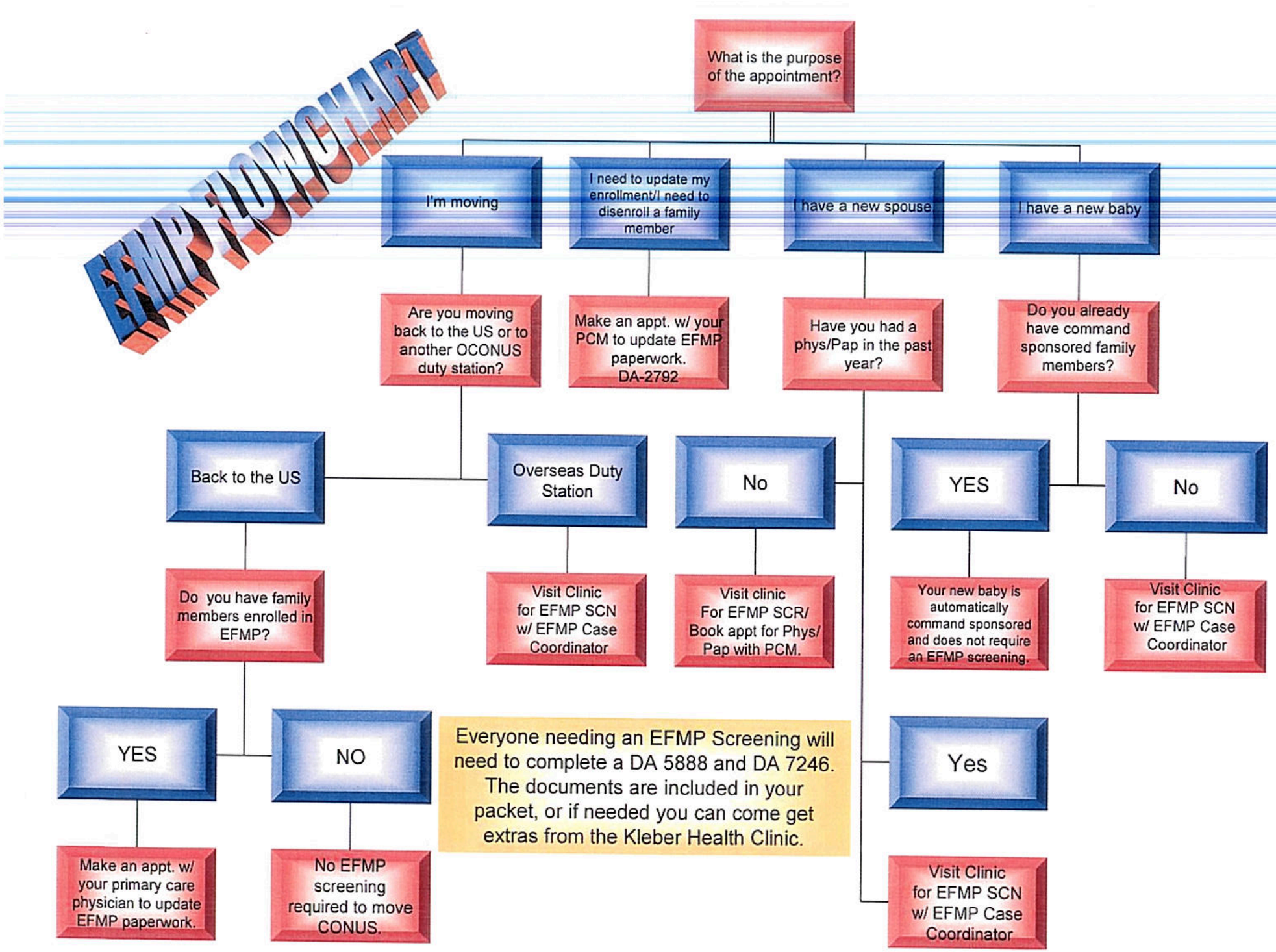
Appointment
line……DSN: 590-2612
Civ: 0637194642612

TRICARE- Landsthul BLDG 3744
Foreign National Liaison……DSN: 590-4830/4100
Civ: 0637164944830/4100

TRICARE- Kleber BLDG 3245 RM 218……590-4830
Civ: 063719464-4830

If you have any questions please call one of the numbers listed above.

EFMP FLOWCHART



EFMP PROCEDURES AND SCREENING GUIDE

CONDITIONS THAT WARRANT ENROLLMENT

- Soldiers who have family members with serious or chronic medical problems, physical disabilities, and mental health disorders.
- Potential life-threatening conditions to include but not limited to asthma.
- Continuous care or multiple episodes of care choric in nature, greater than 6 months.
- Mental health treatment over the past 5 years; or mental health services required at the present time or projected to the future.
- Attention Deficit-Hyperactivity Disorder requiring management and treatment by a pediatrician, mental health care provider, or counselor.
- Follow-up support, such as high-risk newborns and patients diagnosed of cancer within the past 5 years.
- Enroll all soldiers who have family members that require early intervention or special education services.

PROCEDURES

- SM or Spouse obtains DA form 5888-R and 7246. Forms can be obtained from Form Flow, ACS, SM's PAC office or the Health Clinic.
- DA Form 7246 is to be completed by the SM or Spouse.
- On DA Form 5888, the SM or Spouse completes items 1-7. **Next, the DA Form 5888 is taken ti the S1 at BDE or Garrison <u>NOT</u> battalion level for Authentication (item 8).**
- If only an update on a family member's EFMP is needed, DA Form 2792 and 7246 are the forms needed.
- If enrollment into EFMP program is NOT warranted, bring all medical records and complete paperwork DA Form 5888 and DA Form 7246 to the Kleber Health Clinic for processing. The Case Coordinator has one week to review the records.
- If enrollment into the program is warranted, contact the clinic's appointment line at DSN: 590-4212/2643 CIV: 063712612/2643 to schedule an appointment with your PCM. During your appointment you must bring all medical records and completed paperwork.
- Once you have completed all necessary steps and appointments, if needed, then the case coordinator will provide the SM or Spouse with all necessary documentation and copies.

REQUIRED EFMP FORMS
Based on Soldier Action

ACTION	DA 5888	DA 7246	DD 2792	DD 2792-1
Consecutive Overseas Tour (COT)	X	X	If applicable	If applicable
In-place Consecutive Overseas Tour (IPCOT)	X	X	If applicable	If applicable
Intra-theater Tour (ITT)	X	X	If applicable	If applicable
Command Sponsorship (Local National)	X	X	If applicable	If applicable
Foreign Service Tour Extension (FSTE) >6 months	X	X	If applicable	If applicable
Medical Update			X	
Medical Enrollment			X	
Request Medical disenrollment			X	
Educational Update*				X
Educational Enrollment*				X
Request Educational Disenrollment*				X

* Completed by the school **UNLESS** school is out, then **MEDICAL** completes.

Before you arrive for your appointment, make sure you:

- Complete your Kleber Clinic EFMP Worksheet
- Retain copies of all medical records for the past 3 years (If your medical records are not held at a military treatment facility)
- Are your records translated?(If applicable) If they are NOT translated, you must have them translated BEFORE your appointment. (Include any ER visits and hospitalizations)
- Do you have a copy of your active medications FROM YOUR PROVIDER?(If your medical records are not at a military treatment facility)
- Do you have a copy of all recent Lab/Radiology results? (If your medical records are not held at a military treatment facility)
- Are your shot records included and up-to-date?
- Did you complete all areas of responsibility on your DA forms 5888 and 7246? (include DA form 2792 if you have dependents with special needs, enrollment/disenrollment EFMP)

EFMP FAQ

Q: What is the Exceptional Family Member Program (EFMP)?

A: The Exceptional Family Member Program or EFMP is a mandatory U.S. Department of Defense enrollment program that works with other military and civilian agencies to provide comprehensive and coordinated community support, housing, educational, medical, and personnel services worldwide to U.S. military families with special needs. Service members on active duty enroll in the program when they have a family member with a physical, developmental, or emotional or mental disorder requiring specialized services so their needs can be considered in the military personnel assignment process.

Q: How long does the EFMP process take?

A: If you have a dependent that warrants any special medical care (i.e. asthma, diabetes, learning disabilities, mental health issues etc.) then you must come to the Kleber Health Clinic to pick up your EFMP packet, gather and complete all necessary requirements and documents, schedule your appointment and show up **ON TIME**. Each case is different, but if you complete all of your requirements in a timely manner then the process will go by quickly and smoothly.

Q: What if my dependents do NOT have any special needs?

A: You need to completely fill out the DA 5888 and DA 7246. Once you complete your DA 5888 and DA 7246, you must return the documents to the Kleber Health Clinic. After you have dropped off your documents it will take up to **1 WEEK** for your paperwork to be reviewed and processed, so it is imperative that you turn in your documents in a timely manner.

Q: What is involved in the EFMP process?

A: If your dependent requires enrollment, you must gather all information requested and completely fill out the appropriate documentation. Once you have done that then you need to schedule an appointment with your PCM. **ALL FAMILY MEMBERS THAT REQUIRE ENROLLMENT WILL NEED A SEPARATE APPOINTMENT.** During your dependents appointment, your PCM will determine whether it will be beneficial for your dependents to live overseas (OCONUS) or if they must return stateside (CONUS).

If your dependent does not require enrollment, then it is as simple as completing documentation, turning them in on time and waiting 1 week for processing and completion

Q: How often do I need to perform an update to my EFMP enrollment?

A: Every three years or if there is an sufficient change in the to the medical or educational condition

Q: My family member no longer needs to be enrolled in EFMP, what do I do to get them disenrolled?

You must contact the case coordinator so the provider that your family member is being treated by can submit a DA Form 2792 recommending disenrollment from the program.

Q: My family member no longer qualifies as a family member

A: Provide documentation to show that they are no longer your family member so that disenrollment can take place.

Q: Who needs an EFMP screening?

A: Family members of Soldiers requesting **ITT** (Intratheater Transfer), **COT** (Continuous Overseas Tour), **IPCOT** (In-Place Continuous Overseas Tour), **CS** (Command Sponsorship), and **FSTE** (Foreign Service Tour Extension).

INSTRUCTIONS FOR COMPLETING DD FORM 2792, FAMILY MEMBER MEDICAL SUMMARY

GENERAL.

The DD Form 2792 and attached addenda are completed to identify a family member with special medical needs.

The addenda to the medical summary are completed only if noted in Item 10 of the Demographics/Certification section (p.3).

The Exceptional Family Member Program (EFMP)/ Special Needs Identification and Clearance (SNIAC) Screening Coordinator and the Parent/Guardian or Person of Majority Age sign Items 6.b and 13.b only after all addenda have been completed and the form reviewed for completeness and accuracy.

AUTHORIZATION FOR DISCLOSURE (Page 1).

Health Insurance Portability and Accountability Act (HIPAA) Requirement.

Each adult family member must sign for the release of his/her own medical information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority. Please consult with your military treatment facility (MTF) or dental treatment facility (DTF) privacy/HIPAA coordinator about questions regarding authorizations for disclosure.

DEMOGRAPHICS/CERTIFICATION (Page 2).

Items 1. Self-explanatory.

Item 2.a. Family Member (FM). Name of family member described in subsequent pages.

Item 2.b. Self-explanatory.

Item 2.c. Applies to Military medical beneficiary only. The Family Member Prefix is assigned when the family member is enrolled in DEERS.

Items 2.d. - i. Self-explanatory.

Items 3.a. - j. All items refer to the sponsor. Self- explanatory.

Item 4.a. Answer Yes if both spouses are on active duty; otherwise answer No.
If Yes, complete Items 4.b. - e. All items refer to the active duty spouse. Self-explanatory.

IItem 5.a. - d. If Yes, enter Social Security Number, name of sponsor and branch of Service. Military only.

Item 6.a. - c. Parent/Guardian or Person of Majority Age. Parent/guardian or person of majority age certifies that the information contained in the DD 2792 is correct. **Individual must ensure that all forms are completed and attached before signing.**

Item 7. Purpose for Completing the Form (X one). Initial Screening Enrollment - Review of medical history for the family member noted for the purpose of determining eligibility for EFMP. Request for government sponsored travel and/or command sponsorship review of projected location(s). Update to previous evaluation for the family member. Qualifies for a change in EFMP status. Used to disenroll an EFMP when he/she no longer has the medical condition that requires enrollment, or when the EFM no longer qualifies as a dependent.

Item 8. Indicate status of medical condition.

Item 9.a. If yes, complete b. - c.

Item 10. Required Addenda. This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum. **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each Military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Items 11.a. - h. Mark (X) all services being provided to the family member.

Item 12.a. Additional Family Member. Answer Yes if there is any member of the family, not including this patient, who has been identified as having special needs.

Item 12.b. Indicate the number of other family members who have been identified as an EFM. **Do not include the individual named in this summary in the count of family members.**

Items 13.a. - e. EFMP/SNIAC/Screening Coordinator or Advisor name, signature, date, facility address, telephone number. Self-explanatory. **Coordinator must ensure that all forms are complete and attached before signing.**

Item 13.f. This area is reserved for Service-specific guidance to validate the form.

MEDICAL SUMMARY beginning on page 4 must be completed by a qualified medical professional.

Sponsor, spouse, or family member of majority age must sign release authorization on page 1 before this summary is completed.

Item 1.a. - c. Pertains to children under 6 years of age. Self-explanatory.

Items 2.a. - d. Temporary Conditions. Self-explanatory.

Item 3.a. Diagnosis. Enter the diagnosis(es), one per line. With the exception of asthma, cancer or mental health, identify all diagnoses that have been active within the last year. For asthma, cancer or mental health, identify all diagnoses active within the last 5 years.

Item 3.b. ICD or DSM. Enter ICD-9-CM or DSM IV designations. **REQUIRED.**

Item 3.c. Medications and Therapies. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 3.d. Enter per diagnosis the number of outpatient visits, ER visits, hospitalizations and ICU admissions for the last 12 months.

Item 4. Prognosis. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 5. Treatment Plan. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 6. Cancer. Self-explanatory.

Item 7. Minimum Health Care Specialty. Codes in the first column are used by Army coding teams only. In column 1, indicate with an X those specialists essential (required) to meet the needs of the patient. For example, if a developmental pediatrician is a child's primary care provider, but a pediatrician can meet the needs, do not mark developmental pediatrician. In column 2, indicate frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; Bi - Bimonthly; W - Weekly.

Item 8 - Artificial Openings. Self-explanatory.

Item 9 - Environmental/Architectural Considerations. Self-explanatory.

Item 10. Adaptive Equipment/Special Medical Equipment. Self-explanatory.

Item 11. Comments. Enter any additional information that would assist in determining necessary treatment.

Item 12.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and the date the summary was signed. Self-explanatory.

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY (p.8). **To be completed by a qualified medical professional.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- d. Self-explanatory.

Items 3.a.- k. Self-explanatory.

Items 4.a. - f. Self-explanatory.

Items 5.a. - d. Self-explanatory.

Items 6.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

ADDENDUM 2 - MENTAL HEALTH SUMMARY
(pp. 9 - 10). **To be completed by a qualified clinical provider.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a. - d. Self-explanatory. Item 2.b. ICD or DSM is **REQUIRED**.

Item 3. Self-explanatory.

Item 4.a. - i. History. Self-explanatory.

Item 5. Prognosis. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 6. Treatment Plan. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 7. Expected treatment needs within the next year. Mark only one box considering all diagnoses. Self-explanatory.

Item 8. Required Providers and Frequency of Visits. Mark all providers who are required to implement the treatment plan.

Item 9. Comments. Enter any additional information that would assist in determining necessary treatment.

Items 10.a - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS (p.11). **To be completed by a qualified medical professional.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- b. Diagnosis(es). Self-explanatory.

Items 3. Self-explanatory.

Item 4. Coexisting Diagnoses. Indicate coexisting diagnosis.

Item 5. Current Medications. Self-explanatory.

Item 6. Current Interventions/Therapies. Indicate current interventions/therapies, if known.

Item 7. Communication. Self-explanatory.

Item 8. Other Interventions/Therapies Used by the Family. Specify any alternate or complementary therapies used.

Item 9. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 14 if more space is required.

Item 10. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Item 11. Education. Self-explanatory.

Item 12. Required Medical Services. Self-explanatory.

Item 13. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 14. General Comments. Self-explanatory.

Item 15. Provider Information. Official Stamp or printed name and signature of the provider completing this summary and date the summary was signed. Self-explanatory.

FAMILY MEMBER MEDICAL SUMMARY

(To be completed by service member, adult family member, or civilian employee.)
(Read Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires Mar 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12; and E.O. 9397 (SSN) as amended.

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) military assignment personnel to match the special medical needs of family members against the availability of medical services, and (2) civilian personnel officers to advise civilian employees about the availability of medical services to meet the special medical needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at http://privacy.defense.gov/notices.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://privacy.defense.gov/blanket_uses.shtml apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment.
Mandatory for military personnel: failiure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any special medical needs of your dependent can be met at your next duty assignment. Dependent special needs are noted in the official military personnel files which are retrieved by name and Social Security Number.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

By signing this authorization, you confirm you understand your sponsor will have access to the health information contained herein and in addenda. The sponsor may be held accountable for the accuracy and completeness of the DD 2792 and addenda and should review all pages prior to signing on page 2.

I authorize _____ (MTF/DTF/Civilian Provider) (Name of Provider)
to release my patient information to the Relocation or Suitability Screening Office and/or the Exceptional Family Member/Special Needs Program to be used in the family travel review process and/or registration in the Exceptional Family Member Program. The information on this form and addenda may be used for DoD and Service-specific programs to determine whether there are adequate medical, housing and community resources to meet your medical needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs, if EFMP enrollment criteria are met.

c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives from the medical departments, the offices responsible for assignment coordination, and at your request other military agents responsible for care or services.
Start Date: The authorization start date is the date that you sign this form authorizing release of information.
Expiration Date: The authorization shall continue until enrollment in the Exceptional Family Member Program/Special Needs Program is no longer necessary according to criteria specified in DoD Instruction 1315.19, or if family member no longer meets the criteria to qualify as a dependent, or the sponsor is no longer in active military service or employment of the U.S. Government overseas, or completion of assignment coordination, or eligibility determination for specialized services if that is the sole purpose for the completion of the form.

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my or my child's medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed protected information on the basis of this authorization. My revocation will have no impact on disclosures made prior to the revocation.

b. If I authorize my or my child's protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own or my child's protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524. I request and authorize the named provider/treatment facility to release the information described above for the stated purposes.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization. However, failure to coordinate accompanied assignments prior to OCONUS travel may result in ineligibility for TRICARE Prime status.

e. Failure to release this information or any subsequent revocation may result in ineligibility for community based services, and/or accompanied family travel at government expense.

f. Refusal to sign does not preclude the provision of medical and dental information authorized by other regulations and those noted in this document.

NAME OF PATIENT	SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT *(If applicable)*	DATE *(YYYYMMDD)*

DEMOGRAPHICS/CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient

1. PURPOSE OF THIS FORM *(X one)*

- ☐ EFMP REGISTRATION/ENROLLMENT UPDATE
- ☐ REQUEST CHANGE IN EFMP STATUS
- ☐ SUMMARIZE MEDICAL INFORMATION FOR OFFICIAL USES
- ☐ NO LONGER HAVE PREVIOUSLY IDENTIFIED CONDITION
- ☐ FAMILY MEMBER DECEASED*
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP
- ☐ NO LONGER QUALIFIES AS A DEPENDENT*
- ☐ DIVORCE/CHANGE IN CUSTODY*
- ☐ OTHER *(Explain)*:

*(*Maintain documentation to verify change in status - do not update medical information.)*

2.a. FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	b. SPONSOR NAME *(Last, First, Middle Initial)*	c. FAMILY MEMBER PREFIX (FMP)	d. SPONSOR SSN

e. FAMILY MEMBER GENDER *(X)*	f. FAMILY MEMBER DATE OF BIRTH *(YYYYMMDD)*	g. CURRENT FAMILY MEMBER MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*
☐ MALE ☐ FEMALE		
h. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*	i. FAMILY HOME E-MAIL ADDRESS	

3.a. SPONSOR RANK OR GRADE	b. DESIGNATION/NEC/MOS/AFSC *(Military only)*	c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT

d. BRANCH OF SERVICE *(Military only)*

- ☐ ARMY
- ☐ AIR FORCE
- ☐ NAVY
- ☐ MARINE CORPS

e. STATUS *(X one)*

- ☐ REGULAR ACTIVE SERVICE MEMBER
- ☐ RESERVIST
- ☐ CIVILIAN
- ☐ ACTIVE GUARD RESERVE PROGRAM (AGR)
- ☐ NATIONAL GUARD

f. SPONSOR'S CURRENT UNIT MAILING ADDRESS

g. SPONSOR'S OFFICIAL E-MAIL ADDRESS	h. DUTY TELEPHONE NUMBER *(Include Area Code/CountryCode)*	i. MOBILE NUMBER *(Include Area Code/Country Code)*

j. DOES FAMILY MEMBER RESIDE WITH SPONSOR *(X one. If No, explain.)*

- ☐ YES
- ☐ NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military only) (X one. If Yes, complete 4.b. - e. below)*

- ☐ YES
- ☐ NO

b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	c. BRANCH OF SERVICE	d. RANK/RATE	e. SPOUSE SSN

5.a. IS FAMILY MEMBER ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME? *(Military only) (X one)*

- ☐ YES
- ☐ NO

b. IF YES, UNDER WHAT SSN	c. NAME OF SPONSOR *(Last, First, Middle Initial)*	d. BRANCH OF SERVICE

6. CERTIFICATION. **DO NOT CERTIFY BEFORE COMPLETING ENTIRE FORM AND ADDENDA.**

By signing below, we certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked below) is complete and accurate.

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE:

a. PRINTED NAME	b. SIGNATURE	c. DATE *(YYYYMMDD)*

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

FOR ADMINISTRATIVE USE ONLY

7. REQUIRED ACTIONS *(X one)*

- ☐ FIRST REVIEW OF MEDICAL HISTORY FOR THE FAMILY MEMBER
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP - REVIEW PROJECTED LOCATION(S)
- ☐ UPDATE TO A PREVIOUS EVALUATION FOR THE FAMILY MEMBER
- ☐ OTHER *(e.g., Extended Care Health Option Eligibility)*:
- ☐ QUALIFIES FOR CHANGE IN EFMP STATUS:
  - ☐ FAMILY MEMBER NO LONGER HAS PREVIOUSLY IDENTIFIED CONDITION
  - ☐ FAMILY MEMBER NO LONGER QUALIFIES AS A DEPENDENT*
  - ☐ FAMILY MEMBER DECEASED*
  - ☐ DIVORCE/CHANGE IN CUSTODY*

*(*Maintain documentation to verify change in status - do not update medical information.)*

8. SUMMARY *(X one)*

☐ ONGOING MEDICAL CONDITIONS ☐ TEMPORARY MEDICAL CONDITIONS ☐ BOTH

9.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES? *(X one)*

☐ YES ☐ NO *(If Yes, complete 9.b. and c.)*

b. LOCATION OF CASE MANAGER *(X)* ☐ MTF ☐ TRICARE ☐ CIVILIAN

c. CASE MANAGER CONTACT INFORMATION

(1) NAME *(Last, First, Middle Initial)*	(2) TELEPHONE NUMBER *(Include Area Code/Country Code)*	(3) ADDRESS *(Include ZIP Code or APO/FPO)*

10. REQUIRED ADDENDA. Complete Item 1 on Addendum 1 (page 8) and item 1 on Addendum 2 (page 9) and item 1 on Addendum 3 (page 11) AND X box below if:

- ☐ ASTHMA ADDENDUM 1 IS REQUIRED AND ☐ ATTACHED
- ☐ MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED AND ☐ ATTACHED
- ☐ AUTISM SPECTRUM DISORDER/DEVELOPMENTAL DELAY ADDENDUM 3 IS REQUIRED AND ☐ ATTACHED

11. SPECIAL ASSIGNMENT CONSIDERATIONS *(X all that apply)*

- ☐ a. POSSIBLE SPECIAL EDUCATION/EARLY INTERVENTION *(If marked, DD Form 2792-1 must be completed)*
- ☐ b. RECEIVING TRICARE EXTENDED CARE HEALTH OPTION (ECHO) BENEFITS
- ☐ c. RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ d. RECEIVING SOCIAL SECURITY DISABILITY INSURANCE (SSDI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ e. RECEIVING STATE MEDICAID OR MEDICARE WAIVER SERVICES
- ☐ f. RECEIVING VOCATIONAL REHABILITATION SERVICES
- ☐ g. RECEIVING SPECIAL CHILD CARE ACCOMMODATIONS
- ☐ h. OTHER *(Specify)*

12.a. ARE THERE OTHER EFMP MEMBERS IN THE FAMILY *(Not including this family member)*?

☐ YES ☐ NO b. IF YES, HOW MANY? _____

13. ADMINISTRATIVE CERTIFICATION

a. PRINTED NAME *(Last, First, Middle Initial)*	b. TITLE	c. SIGNATURE	d. DATE *(YYYYMMDD)*

e. FACILITY ADDRESS *(Include ZIP Code or APO/FPO)*	f. TELEPHONE NUMBER *(Include area code/Country Code)*	g. OFFICIAL STAMP

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY: To be completed by a Qualified Medical Professional

PART A - PATIENT STATUS *(Authorization by patient or parent/guardian included on Page 1 of this form)*

1. FOR CHILDREN UNDER AGE 6 ONLY

a. IF PATIENT IS LESS THAN 12 MONTHS OLD, WAS IT A PREMATURE BIRTH? *(X one)*

☐ YES ☐ NO

b. DATE OF LAST WELL-CHILD EXAMINATION *(YYYYMMDD)*

c. WERE ALL DEVELOPMENTAL MILESTONES WITHIN NORMAL LIMITS? *(X one. If No, please explain.)*

☐ YES ☐ NO

2. TEMPORARY CONDITIONS THAT MAY IMPACT TRAVEL CONSIDERATIONS IN THE NEXT YEAR

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES

d. TIME FRAME *(Explain anticipated duration of temporary condition and identify any limitations for activities of daily living and travel limitations.)*

3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV Use item 11 (Comments) if more space is needed.

If Asthma or RAD is noted, also complete Asthma Addendum 1.
If Mental Health is noted, to include Attention Deficit Disorders, also complete Mental Health Addendum 2.
If Autism Spectrum Disorder(ASD)/Developmental Delay (DD) is noted, also complete Addendum 3.

a. ACTIVE DIAGNOSIS REQUIRING CARE WITHIN LAST YEAR *(If Asthma, Cancer or Mental Health within last 5 years)*	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES *(Also annotate rare or special consideration medications used within specified time period)*	d. COMPLETE FOR THE LAST 12 MONTHS:	
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

4. PROGNOSIS FOR EACH ACTIVE DIAGNOSIS IDENTIFIED IN PART A, ITEM 3 *(Include expected length of treatment, required participation of family members, and if treatment is ongoing)*

5. TREATMENT PLAN FOR EACH ACTIVE DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned over the next three years)*

6. CANCER, ADDITIONAL INFORMATION *(If not addressed in Items 3, 4, and 5) (Indicate date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment completed.)*

IF TREATMENT COMPLETED, DATE *(YYYYMMDD)* _____

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Professional

PART B - REQUIRED CARE

7. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

INDICATE THE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY *(Twice a year)* Q - QUARTERLY M - MONTHLY BI - BI-MONTHLY W - WEEKLY

		(1) CARE PROVIDER *(X as appropriate)*	(2) FREQUENCY *(See above)*			(1) CARE PROVIDER *(X as appropriate)*	(2) FREQUENCY *(See above)*
C01		a. ALLERGIST/IMMUNOLOGIST		C56		gg. OTORHINOLARYNGOLOGIST	
C52		b. AUDIOLOGIST		C47		hh. ORTHOPEDIC SURGEON - ADULT	
C42		c. CARDIAC/THORACIC SURGEON		C48		ii. ORTHOPEDIC SURGEON - PEDIATRIC	
C02		d. CARDIOLOGIST - ADULT		C77		jj. PAIN CLINIC	
C03		e. CARDIOLOGIST - PEDIATRIC		C72		kk. PEDIATRIC NURSE PRACTITIONER	
C70		f. CLEFT PALATE TEAM - PEDIATRIC		C30		ll. PEDIATRICIAN	
C05		g. DERMATOLOGIST		C49		mm. PEDIATRIC SURGEON	
C06		h. DEVELOPMENTAL PEDIATRICIAN		C32		nn. PHYSIATRIST *(Physical Rehabilitation)*	
C53		i. DIALYSIS TEAM		C58		oo. PHYSICAL THERAPIST	
C07		j. DIETARY/NUTRITION SPECIALIST		C50		pp. PLASTIC SURGEON - ADULT	
C08		k. ENDOCRINOLOGIST - ADULT		C71		qq. PLASTIC SURGEON - PEDIATRIC	
C09		l. ENDOCRINOLOGIST - PEDIATRIC		C35		rr. PSYCHIATRIST - ADULT	
C10		m. FAMILY PRACTITIONER		C36		ss. PSYCHIATRIST - PEDIATRIC	
C11		n. GASTROENTEROLOGIST - ADULT		C72		tt. PSYCHIATRIST NURSE PRACTITIONER	
C12		o. GASTROENTEROLOGIST - PEDIATRIC		C37		uu. PSYCHOLOGIST - ADULT	
C43		p. GENERAL SURGEON		C38		vv. PSYCHOLOGIST - PEDIATRIC	
C14		q. GENETICS		C33		ww. PULMONOLOGIST - ADULT	
C15		r. GYNECOLOGIST		C76		xx. PULMONOLOGIST - PEDIATRIC	
C17		s. HEMATOLOGIST/ONCOLOGIST - ADULT		C60		yy. RESPIRATORY THERAPIST	
C18		t. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C39		zz. RHEUMATOLOGIST - ADULT	
C75		u. INFECTIOUS DISEASE		C40		aaa. RHEUMATOLOGIST - PEDIATRIC	
C20		v. INTERNIST		C61		bbb. SOCIAL WORKER	
C21		w. NEPHROLOGIST - ADULT		C62		ccc. SPEECH AND LANGUAGE PATHOLOGIST	
C22		x. NEPHROLOGIST - PEDIATRIC		C41		ddd. TRANSPLANT TEAM	
C23		y. NEUROLOGIST - ADULT		C51		eee. UROLOGIST - ADULT	
C24		z. NEUROLOGIST - PEDIATRIC		C78		fff. UROLOGIST - PEDIATRIC	
C44		aa. NEUROSURGEON		C99		ggg. OTHER *(Describe)*	
C54		bb. OCCUPATIONAL THERAPIST - ADULT					
C55		cc. OCCUPATIONAL THERAPIST - PEDIATRIC					
C26		dd. OPHTHALMOLOGIST - ADULT					
C27		ee. OPHTHALMOLOGIST - PEDIATRIC					
C57		ff. ORAL SURGEON					

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Professional

8. ARTIFICIAL OPENINGS/PROSTHETICS *(X all that apply)*

☐ YES ☐ NO IF YES:

- ☐ F01 - GASTROSTOMY
- ☐ F02 - TRACHEOSTOMY
- ☐ F03 - CSF SHUNT
- ☐ F04 - CYSTOSTOMY
- ☐ F05 - COLOSTOMY
- ☐ F06 - ILEOSTOMY
- ☐ F07 - OTHER UNSPECIFIED PROSTHETICS *(Specify)*
- ☐ F99 - OTHER UNSPECIFIED OPENING *(Specify)*

9. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

- ☐ R01 - LIMITED STEPS *(If Yes, please explain)*
- ☐ R02 - COMPLETE WHEELCHAIR ACCESSIBILITY
- ☐ R04 - SINGLE STORY/LEVEL HOUSE
- ☐ R05 - CARPET PROHIBITED
- ☐ R99 - OTHER *(Specify)*
- ☐ R03 - AIR CONDITIONING
  - ☐ R03a - TEMPERATURE CONTROL
  - ☐ R03b - HEPA FILTER
  - ☐ R03c - POLLEN CONTROL
  - ☐ R03d - AIR FILTERING

EXPLANATION OF SPECIAL CONSIDERATIONS:

10. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(If marked, describe type of equipment in item 11 (Comments) below.)*

- ☐ L03 - APNEA HOME MONITOR
- ☐ L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY
- ☐ L20 - HOME DIALYSIS MACHINE
- ☐ L13 - HOME NEBULIZER
- ☐ L04 - HEARING AIDS: MAKE: MODEL:
- ☐ L22 - INSULIN PUMP: MAKE: MODEL:
- ☐ L23 - PACEMAKER: MAKE: MODEL:
- ☐ L99 - OTHER *(Specify)*
- ☐ L07 - SPLINTS, BRACES, ORTHOTICS
- ☐ L08 - WHEELCHAIR
- ☐ L12 - HOME OXYGEN THERAPY
- ☐ L14 - HOME VENTILATOR

EXPLANATION OF SPECIAL CONSIDERATIONS:

11. COMMENTS *(Enter additional information to describe this individual's medical needs.)*

PART C - PROVIDER INFORMATION

12.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY: To be completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR TREATED FOR ASTHMA WITHIN THE PAST 5 YEARS.

☐ NO ☐ YES IF YES, CONTINUE COMPLETION OF ASTHMA ADDENDUM ITEMS 2 - 6.

2. MEDICATION HISTORY

a. MEDICATION	b. DOSAGE	c. FREQUENCY	d. APPROXIMATE DATE MEDICATION LAST USED

3. HISTORY ASSOCIATED WITH ASTHMA ATTACKS *(X as applicable)*

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS *(stress, environment, exercise)*?
		b. DOES THE FAMILY MEMBER ROUTINELY *(greater than 10 days per month/four months per year)* USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR *(prednisone, prednisolone)*? IF YES, NUMBER OF DAYS IN PAST YEAR:
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE FAMILY MEMBER REQUIRED AN URGENT VISIT TO THE ER OR CLINIC FOR ACUTE ASTHMA DURING THE PAST YEAR? IF "YES', INDICATE THE NUMBER OF VISITS IN THE PAST YEAR:
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE *(pneumonia, bronchitis, bronchiolitis, croup, RSV)* DURING THE PAST YEAR? IF "YES', INDICATE THE DATE(S) OF HOSPITALIZATION *(YYYYMMDD)*:
		g. DOES THE FAMILY MEMBER HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST 5 YEARS? IF "YES', HOW MANY? INDICATE DATE OF LAST ADMISSION *(YYYYMMDD)*:
		h. HAS THE FAMILY MEMBER REQUIRED MECHANICAL VENTILATION *(Intubation/use of respirator)* DURING THE PAST 3 YEARS?
		i. DOES THE FAMILY MEMBER HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?

j. HOW MANY DAYS HAS THE FAMILY MEMBER MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS *(including visits to physicians)* DURING THE PAST YEAR?

k. HOW OFTEN DOES THE FAMILLY MEMBER USE HIS/HER RESCUE INHALER OR NEBULIZER MEDICATION *(such as Albuterol or Levalbuterol)* FOR INCREASED OR ACUTE SYMPTOMS?

4. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? *(X as applicable)*

(1) ACTIVITY	(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3 - 7 TIMES A YEAR	(5) 8 - 10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP							
b. QUIET ACTIVITY							
c. SOCIALIZING WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

5. SEVERITY LEVEL. What is the family member's severity level based on the current treatment plan? *(Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)*

☐ a. **INTERMITTENT ASTHMA.** Intermittent symptoms ≤ 1 time per week. Brief exacerbations (from a few hours to a few days). Nighttime asthma symptoms < 2 times a month. Asymptomatic and normal lung function between exacerbations. PEF or FEV1 ≥ 80% predicted; variability <20%.

☐ b. **MILD PERSISTENT ASTHMA.** Symptoms ≥ 2 times a week but < 1 time per day. Exacerbations may affect sleep and activity. Nighttime asthma symptoms > 2 times a month. PEF or FEV1 ≥ 80% predicted; variability 20 - 30%.

☐ c. **MODERATE PERSISTENT.** Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma > 1 time a week. Daily use of inhaled short-acting B2 agonist. PEF or FEV1 ≥ 60% and 80% predicted; variability > 30%.

☐ d. **SEVERE PERSISTENT.** Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 ≤ 60% predicted; variability > 30%.

6.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY: To be Completed by a Qualified Clinical Provider

1. PATIENT HAS CURRENT OR PAST *(within the last 5 years)* **HISTORY OF MENTAL HEALTH DIAGNOSIS** *(To include attention deficit disorders)*

☐ NO ☐ YES IF YES, CONTINUE WITH COMPLETION OF MENTAL HEALTH ADDENDUM.

2. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV.

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. AGE AT DIAGNOSIS	d. COMPLETE FOR THE LAST 5 YEARS
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:

3. MEDICATION HISTORY RELATED TO THE DIAGNOSIS LISTED ABOVE; THERAPIES RECEIVED OR RECOMMENDED
(Including frequency of medication and therapy, and their effectiveness)

4. HISTORY

YES	NO	WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD:
		a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?
		b. HISTORY OF SUBSTANCE ABUSE?
		c. HISTORY OF ADDICTIVE BEHAVIORS?
		d. HISTORY OF EATING DISORDERS?
		e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?
		f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY? *(If Yes, specify)*
		g. HISTORY OF PSYCHOTIC EPISODES?
		h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? *(If Yes, and services are delivered by Family Advocacy, note case determination.)*

i. COMMENTS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY *(Continued)*: To be Completed by a Qualified Clinical Provider

5. PROGNOSIS *(Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)*

6. TREATMENT PLAN *(Medical, mental health, surgical procedures or therapies related to the patient's mental health condition planned over the next three years)*

7. TREATMENT NEEDS WITHIN THE NEXT YEAR *(Consider increased stressors of residing in new environment (e.g.,stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)*

8. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN AND FREQUENCY OF VISITS

☐ PSYCHIATRIST	☐ PSYCHOLOGIST	☐ SOCIAL WORKER	☐ OTHER *(Specify)*
☐ WEEKLY	☐ WEEKLY	☐ WEEKLY	☐ WEEKLY
☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY
☐ MONTHLY	☐ MONTHLY	☐ MONTHLY	☐ MONTHLY
☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY
☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY

9. OTHER COMMENTS *(Include additional information that would assist in determining necessary treatments.)*

10. PROVIDER INFORMATION *(Authorization by patient included on Page 1 of this form.)*

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS

To be Completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR RECEIVED TREATMENT(S) FOR AUTISM SPECTRUM DISORDERS AND/OR SIGNIFICANT DEVELOPMENTAL DELAYS *(X one)*

☐ NO ☐ YES IF YES, CONTINUE WITH COMPLETION OF AUTISM AND SIGNIFICANT DEVELOPMENTAL DELAYS ADDENDUM 3, ITEMS 2 - 15.

2.a. DIAGNOSIS(ES) *(X and complete as applicable)*

☐ AUTISTIC DISORDER
☐ ASPERGER'S SYNDROME
☐ OTHER *(Specify)*
☐ PERVASIVE DEVELOPMENTAL DISORDER/NOS

b. AGE WHEN DIAGNOSED

3. DATE OF BIRTH *(YYYYMMDD)*

c. DIAGNOSED BY:

☐ CHILD PSYCHOLOGIST
☐ CHILD PSYCHIATRIST
☐ DEVELOPMENTAL PEDIATRICIAN
☐ MEDICAL MULTIDISCIPLINARY TEAM
☐ OTHER PHYSICIAN
☐ SCHOOL-BASED TEAM
☐ OTHER *(Specify)*

4. COEXISTING DIAGNOSES *(X all that apply)*

☐ CHROMOSOMAL ABNORMALITIES
☐ OBSESSIVE COMPULSIVE DISORDER
☐ ATTENTION DEFICIT/HYPERACTIVITY DISORDER
☐ INTERMITTENT EXPLOSIVE DISORDER
☐ CIRCADIAN-RHYTHM SLEEP DISORDER
☐ GENERALIZED ANXIETY DISORDER, ANXIETY DISORDER, NOS
☐ MAJOR DEPRESSIVE DISORDER, DEPRESSIVE DISORDER, NOS
☐ SEIZURE DISORDER
☐ OTHER *(Specify)*

5. CURRENT MEDICATIONS *(Used to treat diagnoses on this page)*

6. CURRENT INTERVENTION THERAPIES

(1) TYPE	(2) SCHOOL HOURS/WEEK *(If known)*	(3) TRICARE HOURS/WEEK *(If known)*	(4) OTHER SOURCE HOURS/WEEK *(If known)*	(5) OTHER *(Identify)*
a. SPEECH THERAPY				
b. OCCUPATIONAL THERAPY				
c. PHYSICAL THERAPY				
d. PSYCHOLOGICAL/COUNSELING				
e. INTENSIVE BEHAVIORAL INTERVENTION *(Includes ABA)*				
f. OTHER *(Specify)*				

7. COMMUNICATION *(X)*

☐ VERBAL ☐ NON-VERBAL *(Uses:)*
☐ SIGNING
☐ PICTURE EXCHANGE COMMUNICATION SYSTEM (PECS)
☐ COMMUNICATION DEVICE
☐ COMBINATION

8. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY *(Specify alternate or complementary therapies)*

9. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR

☐ YES ☐ NO *(If Yes, provide details in Item 14 below)*

10. COGNITIVE ABILITY *(X)*

☐ <50
☐ 50 - 70
☐ >70
☐ UNKNOWN
☐ INDETERMINATE

11. EDUCATION *(X)*

☐ RECEIVES EARLY INTERVENTION
☐ RECEIVES SPECIAL EDUCATION
☐ ATTENDS SPECIAL PRIVATE SCHOOL
☐ ATTENDS PUBLIC SCHOOL
☐ ATTENDS PRIVATE SCHOOL
☐ IS HOME SCHOOLED

12. REQUIRED MEDICAL SERVICES *(X)*

☐ CHILD PSYCHOLOGY
☐ CHILD PSYCHIATRY
☐ OTHER *(Specify)*
☐ CHILD NEUROLOGY
☐ DEVELOPMENTAL PEDIATRICS

13. RESPITE CARE RECEIVED

a. HOURS PER MONTH	b. SOURCE

14. GENERAL COMMENTS *(Include Functional Levels)*

15. PROVIDER INFORMATION

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12; and E.O. 9397 (SSN) as amended.

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special education needs of family members. This information will enable: (1) Military assignment personnel to match the special education needs of family members against the availability of educational services, and (2) Civilian personnel officers to advise civilian employees about the availability of education services to meet the special education needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at http://privacy.defense.gov/notices.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://privacy.defense.gov/blanket_uses.shtml apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; however, the information must be provided if you intend to enroll your child with special education needs in a school funded by the Department of Defense.
Mandatory for military personnel. Failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the DoD Education Activity and Service personnel offices to work together to ensure any special education needs of your dependent can be met at your next duty assignment. Dependent special education needs are noted in the official military personnel files which are retrieved by name and Social Security Number.

INSTRUCTIONS

The DD Form 2792-1 is completed to identify a family member with special educational/early intervention needs.

DEMOGRAPHICS.

Items 1 - 7. Completed by sponsor or spouse.

Item 1. Request (X one):
- EFMP Registration/Enrollment Update - first exceptional family member (EFM) application for the family member or to update a previous EFM evaluation for the family member.
- Government sponsored travel and/or Command Sponsorship.
- Change in EFMP Status.

Items 2.a. - g. Child/Student Information. Self-explanatory.

Items 3.a. - j. Sponsor Information. Self-explanatory.

Item 3.k. Is family member enrolled in DEERS? Military only. Self-explanatory.

Items 4.a. - d. Self-explanatory.

Item 5. Completed for children age birth to 3 only. Self-explanatory.

Item 6. Completed for children ages 3 to 21 only. Self-explanatory.

Items 7.a. - c. Signature of sponsor or spouse who completed the form. Self-explanatory.

Items 8.a. - f. Administrative Review. Completed by EFMP/Special Needs Office resonsible for screening or enrollment in the MTF.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

DD Form 2792-1 is completed by the parents and school or early intervention staff. **Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for EFMP screening or enrollment.**

Items 1.a. - d. Sponsor Information. Completed by sponsor or spouse. Self-explanatory.

Items 2.a. - d. Child/Student Information. Completed by sponsor or spouse. Self-explanatory.

Items 3.a. - e. EIP Information. Completed by EIP or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Items 4.a. - g. School Information. Completed by school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Item 5. Completed by school personnel. Mark (X) eligibility category. Mark only one. (Codes are for Army coding only.)

Item 6. Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

Item 7. Completed by EIP and school personnel. Self-explanatory.

Item 8. Completed by EIP provider/school official information completing form. Self-explanatory.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

(Page 1, Items 1 - 7 to be completed by sponsor, parent or legal guardian.)
(Read Privacy Act Statement and Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires
Mar 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

DEMOGRAPHICS

1. REQUEST *(X one)*

- ☐ EFMP Registration/Enrollment Update
- ☐ Government Sponsored Travel and/or Command Sponsorship
- ☐ Change in EFMP Status:
  - ☐ No longer requires IEP/IFSP services
  - ☐ No longer qualifies as a dependent*
  - ☐ Divorce/change in custody*
- ☐ Other *(Explain)*:

*(*Provide documentation for change in status)*

2.a. CHILD/STUDENT NAME *(Last, First, Middle Initial)*	b. SPONSOR NAME *(Last, First, Middle Initial)*	c. CHILD/STUDENT CURRENT MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*
d. CHILD/STUDENT DATE OF BIRTH *(YYYYMMDD)*	e. CHILD/STUDENT GENDER *(X one)* ☐ MALE ☐ FEMALE	
f. FAMILY HOME E-MAIL ADDRESS	g. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*	

3.a. SPONSOR RANK OR GRADE	b. DESIGNATION/NEC/MOS/AFSC *(Military only)*	c. INSTALLATION OF CURRENT ASSIGNMENT
d. SPONSOR'S OFFICIAL E-MAIL ADDRESS	e. DUTY TELEPHONE NUMBER *(Include Area Code/Country Code)*	f. MOBILE NUMBER *(Include Area Code/Country Code)*

g. SPONSOR'S CURRENT UNIT MAILING ADDRESS	h. STATUS *(X one)*	d. BRANCH OF SERVICE *(Military only)*
	☐ Regular Active Service Member ☐ Active Guard/Reserve Program (AGR) ☐ Reservist ☐ National Guard ☐ Civilian	☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps

j. DOES CHILD RESIDE WITH SPONSOR? *(X one. If No, explain.)*

☐ YES ☐ NO

k. IS THE CHILD/STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE? *(X one. If Yes, provide name of sponsor:)*

☐ YES ☐ NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military only) (X one. If Yes, answer b. - d. below)*

☐ YES ☐ NO	b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	c. BRANCH OF SERVICE	d. RANK/RATE

5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY:

☐ YES ☐ NO Is your child being evaluated for, or receiving, early intervention services on an Individualized Family Service Plan (IFSP)?
(X one. If No, sign Item 7 and return to the requesting office. If Yes, have early intervention professional complete Page 2.)

6. FOR STUDENTS AGES 3 - 21 WHO ARE ELIGIBLE FOR ELEMENTARY AND SECONDARY EDUCATION:

☐ YES ☐ NO a. Is your child being home-schooled? *(X one. If No, sign Item 7 and take Page 2 to your child's school. If Yes, complete the following and sign Item 7.)*

b. When did you start home-schooling? *(YYYYMMDD)* _____

c. List any special education-related services received in the last 3 years:

_____

d. Name/title home school program, if known: _____

7.a. SIGNATURE	b. PRINTED NAME *(Last, First, Middle Initial)*	c. DATE *(YYYYMMDD)*

8. ADMINISTRATIVE REVIEW *(Completed after review of entire form by local military MTF or office receiving form)*

a. SPONSOR SSN	b. SPOUSE SSN *(If dual military)*	c. SSN USED IN DEERS *(If different from sponsor's)*	STAMP
d. FAMILY MEMBER PREFIX	e. MILITARY MTF OR OFFICE RECEIVING COMPLETED FORM	f. DATE *(YYYYMMDD)*	

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM:

It is important to the military and to the family that the family be assigned to a location that can meet the child's educational needs. Your support in completing this form is appreciated. *(If applicable, attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) or Section 504 Plan to this page.)*

1. RELEASE OF INFORMATION *(To be completed by sponsor, spouse, or student who has reached the age of majority)*

I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to personnel of the Military Departments. This information will be used to evaluate and document my child/student's needs for educational services for the purpose of assignment/coordination, EFMP registration or eligibility for other educationally related benefits.

a. SIGNATURE OF SPONSOR, SPOUSE, OR STUDENT WHO HAS REACHED THE AGE OF MAJORITY	b. PRINTED NAME	c. RELATIONSHIP TO CHILD/ STUDENT	d. DATE *(YYYYMMDD)*

2. CHILD/STUDENT INFORMATION *(To be completed by sponsor or spouse)*

a. NAME OF CHILD/STUDENT *(Last, First, Middle Initial)*	b. CURRENT GRADE LEVEL *(If school age)*	c. DATE OF BIRTH *(YYYYMMDD)*	d. GENDER *(X one)*
			☐ FEMALE ☐ MALE

3. EARLY INTERVENTION (EI) SERVICES - FOR CHILDREN UNDER 3 YEARS OF AGE *(To be completed by EI representative)*

YES	NO	
☐	☐	a. Is the child currently being evaluated for early intervention services? *(If Yes, go directly to Item 8.)*
☐	☐	b. Does this child receive early intervention services under a current Individualized Family Services Plan (IFSP)?

(If Yes, please attach current IFSP.) Date of next annual review *(YYYYMMDD)*: _____

c. Basis for eligibility: ☐ Developmental delay ☐ High probability for developmental delay

d. Identified disability for diagnosis: _____

4. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21 *(To be completed by school representative)*

YES	NO	
☐	☐	a. Is the student receiving services under a 504 plan? *(If Yes, please attach a copy of the current 504 plan.)*
☐	☐	b. Has this child ever been evaluated for, or been offered, special education services by your school? *(If No, skip to Item 8.)*
☐	☐	c. Is this student currently being evaluated for special education services? *(If Yes, skip to Item 8.)*
☐	☐	d. If your school determined the student eligible for special education services within the past 3 years, did the parent decline special education services? *(If Yes, complete eligibility information in Item 5 and proceed to Item 8.)*
☐	☐	e. Does this child/student receive special education services under a current Individualized Education Program (IEP)? *(If Yes, please attach a copy of the current IEP, and complete Items 5 and following.)* Date of next annual review *(YYYYMMDD)*: _____
☐	☐	f. Were IEP services terminated by the IEP team within the last 2 years? *(If Yes, skip to Item 8.)* Date of IEP termination *(YYYYMMDD)*: _____
☐	☐	g. Was the IEP terminated at the request of the parents within the last year (parents withdrew student from special education)? *(If Yes, complete Items 5 and following.)*

5. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE *(X only one)*

☐	N07	Autism Spectrum Disorder:	☐	N09	Communication Impaired:	☐	N12	Specific Learning Disability
☐		Autism	☐		Articulation	☐	N10	Emotionally Impaired
☐		PDD-NOS	☐		Dysfluency	☐	N16	Behavioral/Conduct Disorder
☐		Asperger's Syndrome	☐		Voice	☐	N04	Mental Retardation:
☐	N01	Deaf	☐		Language/Phonology	☐		Mild/Moderate
☐	N02	Blind	☐	N05	Traumatic Brain Injury	☐		Moderate/Severe
☐	N13	Deaf/Blind	☐	N03	Hearing Impaired	☐		Severe/Profound
☐	N11	Visually Impaired	☐	N06	Orthopedically Impaired	☐	N08	Other Health Impaired *(Specify)*

6. RELATED SERVICES ON IEP *(X boxes next to related services and indicate total number of minutes or hours that services are provided.)*

SERVICE: M = Minutes, H = Hours per W = Week, M = Month Example:		20	M	per	W
☐	R01 Counseling			per	
☐	R02 Occupational Therapy			per	
☐	R03 Physical Therapy			per	
☐	R04 Speech Therapy			per	
☐	R05 Intensive Behavioral Intervention *(Such as ABA)*			per	

☐ R06 Special Transportation *(Describe)*:

☐ R07 Other *(Describe)*:

7. BEHAVIOR/COMMUNICATION *(X all that apply and explain in comments section.)*

YES	NO	
☐	☐	a. Child exhibits high risk or dangerous behavior.
☐	☐	b. Child is verbal *(If No, answer c.-f. The student uses:)*
☐	☐	c. Signing *(Specify language or system)*
☐	☐	d. Picture Exchange Communication System (PECS)
☐	☐	e. Communication Device *(Specify)*
☐	☐	f. Other *(Specify)*

g. COMMENTS

8. PROVIDER/SCHOOL INFORMATION

a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL	b. SCHOOL DISTRICT
c. ADDRESS *(Street, City, State,ZIP Code, APO/FPO)*	d. TELEPHONE NUMBER *(Include Area Code/ Country Code)*

e. FAX NUMBER *(Include Area Code/ Country Code)*	f. E-MAIL ADDRESS	g. NAME OF INDIVIDUAL COMPLETING THIS SECTION

h. SIGNATURE	i. TITLE	j. DATE SIGNED *(YYYYMMDD)*

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 10, USC Section 3013.
PRINCIPAL PURPOSE:	Personnel support.
ROUTINE USES:	To validate family member deployment screening, and to provide gaining command with data to assist in making an assignment decision.
DISCLOSURE:	The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER *(Last, first, MI)*	2. SOCIAL SECURITY NUMBER	3a. RANK	3b. MOS/BRANCH
4a. HOME ADDRESS	5a. DUTY ADDRESS		6. DATE OF EDAS CYCLE OR RFO *(OFF)* DATE
4b. HOME PHONE NO. *(Include Area Code)*	5b. DUTY PHONE NO. a. DSN b. COMMERCIAL *(Include area code)*		

7. FAMILY MEMBERS

a. NAME	b. RELATIONSHIP	c. DOB *(YYYYMMDD)*	d. HOME ADDRESS

8. AUTHENTICATION

a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME	c. RANK *(Grade)*	d. SIGNATURE
b. TITLE		e. DATE *(YYYYMMDD)*

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM *(EFMP)* ENROLLMENT *(Check one)*				
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED *(Date sent for Coding)*	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT		
			NO	YES	DATE SENT FOR CODING

10. ARMY MEDICAL TREATMENT FACILITY *(MTF)* EFMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER	b. SIGNATURE	c. DATE *(YYYYMMDD)*
d. ADDRESS	e. PHONE NUMBER *(Include Commercial and DSN)*	

11. ARMY MTF EFMP PHYSICIAN'S AUTHENTICATION *(To be signed when a medical practitioner other than a physician completes this form.)*

a. TYPED OR PRINTED NAME OF PHYSICIAN	b. TITLE	c. RANK
d. SIGNATURE	e. DATE *(YYYYMMDD)*	

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME OF MEDICAL TREATMENT FACILITY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: PL 94-142 *(Education for all Handicapped Children Act of 1975)*, PL 95-561 *(Defense Dependents' Education Act of 1978)*; DODI 1342.12 *(Education of Handicapped Children in DODDS)*, 17 December 1981; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States)*, 28 August 1986, 10 USC 3013; 20 USC 921-932 and 1401 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of family members.

This will permit consideration of special education and medical needs of family members in the personnel

ROUTINE USES: Information will be used by personnel of the Military Departments to evaluate and document special education and medical needs of family members for consideration in personnel assignments.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude U.S. Total Personnel Command from enrolling soldiers in the EFMP. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. Refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

SERVICE MEMBER'S NAME/RANK		DATE *(YYYYMMDD)*
BRANCH	UNIT	DUTY PHONE
PROJECTED PCS ASSIGNMENT	DSN	HOME PHONE
PROJECTED PCS DATE	HOME ADDRESS	DUTY ADDRESS

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH *(YYYYMMDD)*	CHECK IF ENROLLED IN EFMP
				☐
				☐
				☐
				☐
				☐

PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY

MEDICAL

1. Do any family members, excluding service member, have any medical records *(civilian or military)* other than the records you have provided us to screen? If yes, please list conditions/services received and address of provider. YES ☐ NO ☐

FAMILY MEMBER	CONDITIONS/SERVICES	NAME/ADDRESS OF PROVIDER

2. In the past five *(5)* years, have any members of your family, excluding service member, been hospitalized, excluding hospitalization for normal uncomplicated childbirth? If yes, please explain. YES ☐ NO ☐

NAME	REASON

3. Are any members of your family, excluding service member, currently receiving medical *(includes mental health)* or educational services from any providers other than a general practitioner or family practice physician? YES ☐ NO ☐

4. Are any family members, excluding service member, taking any prescribed medication other than birth control pills on a regular basis? YES ☐ NO ☐

NAME	PRESCRIBED MEDICATION

5. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Problems with sight *(other than corrected by glasses)*	☐	☐	g.	Asthma, allergies or other respiratory problems	☐	☐
b.	Problems with hearing	☐	☐	h.	Cerebral Palsy	☐	☐
c.	Heart condition	☐	☐	i.	Delayed Speech	☐	☐
d.	Seizure disorder	☐	☐	j.	Sickle Cell Trait/Disease	☐	☐
e.	Loss of mobility *(requiring use of a wheelchair/ walker or aid in mobility)*	☐	☐	k.	Cancer	☐	☐
				l.	High blood pressure	☐	☐
f.	Diabetes	☐	☐	m.	Other, if yes, explain	☐	☐

MENTAL HEALTH:

6. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem	☐	☐	d.	Alcohol and drug use or abuse	☐	☐
				e.	Emotional problems	☐	☐
b.	Depression	☐	☐	f.	Behavioral problems/acting out behavior	☐	☐
c.	Suicidal thoughts/ideas, gestures, attempts	☐	☐	g.	Received therapy *(marital, family, individual or group counseling)*	☐	☐

7. Have any members of your family, excluding service member, been in any of the following? Inpatient Psychiatric Facility, Residential Treatment Center, Group Homes, Day Treatment Centers, Drug and Alcohol Treatment Rehabilitation Center. If Yes, please explain: YES ☐ NO ☐

EDUCATION

8. Do any of your children now have, or have they ever had, any of the following?

		YES	NO			YES	NO
a.	Slow development *(infants and preschoolers)*	☐	☐	d.	Counseling services for school-related problems	☐	☐
b.	Learning problems *(school)*	☐	☐				
c.	Special services *(i.e., OT, PT, Speech, etc.)* for special education	☐	☐	e.	Mental retardation	☐	☐

9. Are any of your children receiving Special Education help in school *(not in regular class placement and on an Individual Education Plan (IEP))*? If yes, who? YES ☐ NO ☐

According to AR 608-75, Exceptional Family Member Program, soldiers will provide accurate information as required when requested to do so by Army officials. Knowingly providing false information in this regard may be the basis for disciplinary or administrative action. For soldiers, refusal to provide information may preclude successful processing of an application for family travel or command sponsorship.

Commanders will take appropriate action against soldiers who knowingly provide false information, or who knowingly fail or refuse to enroll family members that meet the criteria for enrollment. *(A false official statement is a violation of Article 107, Uniform Code of Military Justice (UCMJ).)* These actions will include, at a minimum, a general officer letter of reprimand.

All the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to provide any information about changes in medical or educational status for all members of my family, after the date indicated below, and prior to PCS move.

PRINTED NAME OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	SIGNATURE OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM	DATE *(YYYYMMDD)*
PRINTED NAME OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	SIGNATURE OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	DATE *(YYYYMMDD)*